EMPLOYMENT DEVELOPMENT DEPARTMENT

Amendment of Sections 2712-1, 2712-2, 3253-1, 3254-2,
and Adoption of Section 3254-4 of
Title 22, California Code of Regulations

VOLUNTARY PLANS—FAMILY TEMPORARY DISABILITY INSURANCE

Final Statement of Reasons

BACKGROUND:

The Employment Development Department (Department) extends approval to employers to operate voluntary plans for short-term disability insurance coverage, in lieu of State Disability Insurance (SDI) coverage, as set forth in Division 1, Part 2, Chapter 6, of the California Unemployment Insurance Code (code) and California Code of Regulations (CCR), title 22. The express purpose of Part 2 of the code is to compensate in part for the wage loss sustained by individuals unemployed because of sickness or injury.

Senate Bill 1661 (Stats. 2002, Ch. 901) and Senate Bill 727 (Stats. 2003, Ch. 797) created and added the Family Temporary Disability Insurance (FTDI) benefit program as a component to California's State Disability Insurance program. The FTDI benefit program, also known as the Paid Family Leave (PFL) insurance program, provides partial wage replacement to workers taking family care leave and is administered in accordance with the provisions of Part 2 of the code.

The FTDI program was created for workers who are unable to perform their regular and customary work when they are either providing care to a seriously ill child, spouse, parent, registered domestic partner, or bonding with a new minor child. Workers may be eligible for FTDI benefits for claims commencing on and after July 1, 2004. Voluntary plan employers must comply with the FTDI benefit provisions created by Senate Bills 1661 and 727. The proposed regulatory amendments explain this new component of the SDI program and its effect on voluntary plans.

NECESSITY:

Under code sections 305 and 306, the Department is authorized to adopt, amend, or repeal regulations for the administration of the functions of the Department. Under code sections 2625, 2706, 2708, 3301, 3302, and 3303, benefits are payable from the Disability Fund to individuals who file claims for benefits in accordance with authorized regulations and are eligible to receive such benefits. Under code sections 3251, 3253, 3254, and 3255, a qualified employer is able to provide the benefits to employees electing coverage under the employer's voluntary plan.

These proposed regulations explain the expanded statutory responsibilities of the SDI program and voluntary plans.

This regulatory action will ensure that the public peace, health and safety, and general welfare are protected.

Section 2712-1. Dispute Between Department and a Voluntary Plan Where Claim Filed with the Department.

Section 2712-1 requires that if the Department determines that a voluntary plan as defined in Chapter 6, Part 2, Division 1, of the code commencing with Section 3251 et seq. is liable for a disability benefits claim, the Department must forward to that liable party the claim records with a request for reimbursement. Subdivision (a) is amended to apply this requirement to claims for FTDI benefits.

Section 2712-2. Dispute Between Department and a Voluntary Plan or Different Voluntary Plans Where Claim Filed Against a Voluntary Plan.

Section 2712-2 requires that if a voluntary plan as defined in Chapter 6, Part 2, Division 1, of the code commencing with Section 3251 et seq. determines that the Department is liable for a disability benefits claim, the voluntary plan as defined in Chapter 6, Part 2, Division 1, of the code commencing with Section 3251 et seq. must forward the claim records with a request for reimbursement to the Department. Subdivision (c) is added to apply this requirement to claims for FTDI benefits.

State and federal law prohibit the disclosure of a care recipient's medical information to third parties without his or her prior written authorization. Subdivision (c) is added to make subdivisions (a) and (b) applicable to claims for FTDI benefits. Subdivision (d) is added to ensure compliance by voluntary plans as defined in Chapter 6, Part 2, Division 1, of the code commencing with Section 3251 et seq. with this requirement. Subdivision (d) specifies the minimum elements that an authorization must contain so that it complies with the state and federal laws.

Section 3253-1. Payment of Disability Benefits Because of Simultaneous Coverage.

The laws that created the FTDI benefit program introduce the 12-month period, a concept that is unique to FTDI, which permits claimants to provide care intermittently for the same care recipient. Illustrations are necessary to clarify how this concept applies when a claimant files more than one FTDI claim for the same care recipient within a 12-month period. An individual may be covered by the State Plan, a voluntary plan as defined in Chapter 6, Part 2, Division 1 of the code commencing with Section 3251 et seq., or simultaneously by both. Therefore, it is necessary to illustrate with examples how liability for FTDI claims may shift between plans within the 12-month period.

The first paragraph was amended to make reference to FTDI benefits. The second paragraph was renumbered as subdivision (a) and amended to distinguish claims filed by disabled claimants from claims for FTDI benefits. Subdivision (b) was added to describe the application of simultaneous coverage to claims for FTDI benefits.

Section 3254-2. General Provisions for a Voluntary Plan.

This section describes the basic requirements that a voluntary plan as defined in Chapter 6, Part 2, Division 1, of the code commencing with Section 3251 et seq. must meet for approval by the director of the Department. This section is amended so that the basic requirements also apply to FTDI benefits.

Subdivision (d) was amended to reference FTDI benefits and to prohibit voluntary plans from excluding individuals from coverage because of their pre-existing physical or mental condition or that of their family member.

Subdivision (d)(2) was added to show when a care recipient period commences.

Subdivision (f) was amended to include FTDI in the provisions relating to the election of voluntary plan coverage after first being admissible to the plan.

Subdivision (h) was amended to reflect that simultaneous coverage applies to claims for disability and claims for FTDI benefits.

Section 3254-4. Termination of Family Temporary Disability Insurance Coverage Under a Voluntary Plan.

Currently, the Department has no regulation that explains the circumstances in which coverage of FTDI claims terminates. Moreover, amending existing regulations would be inappropriate because of several concepts that are unique to FTDI. Therefore, it is necessary to adopt a new regulation that illustrates through examples the application of these concepts.

For example, this section explains that coverage for FTDI benefits remains with the plan or plans that covered the employee when the care recipient period was established. This section also defines a “care recipient period” as all periods of family care leave that an employee takes within a 12-month period to care for the same care recipient.

PLAIN ENGLISH CONFORMING STATEMENT:

The Department has drafted the proposed regulatory action in plain English pursuant to section 11346.2(a)(1) of the Government Code.

EFFECTIVE DATE OF EMERGENCY REGULATIONS:

The proposed regulatory changes were filed with the Secretary of State and took effect as emergency regulations on July 1, 2004.

PUBLIC NOTICE, PUBLIC HEARING, AND WRITTEN COMMENT PERIOD:

On July 30, 2004, the Office of Administrative Law printed a public notice for this regulatory action in the California Regulatory Notice Register, and the Department posted this public notice on its Internet website. A copy of the public notice, the text of the proposed regulations, and the initial statement of reasons were mailed to everyone known to be interested in the Department's regulations.

The Department held a public hearing on September 15, 2004; however, no oral testimony or written comments were provided at the hearing. However, during the public comment period which was held from July 30 through September 15, 2004, written comments were received from one individual on the proposed regulatory action (the written comments are included as part of this rulemaking file at Tab 5). The Department made no additional substantive changes to the emergency regulations as a result of the comments received.

SUMMARY OF PUBLIC COMMENTS:

The Department received one letter dated September 14, 2004, regarding this regulatory action from Attorney Donald C. Carroll of Carroll & Scully on behalf of the California Labor Federation, AFL-CIO.

1. Summary of Comments:

Mr. Carroll objects to the disclosure-authorization requirement contained in proposed Section 2712-2, subdivision (d)(6). Mr. Carroll states that it should not be necessary for the care recipient to choose between disclosing his or her health condition to the care provider and receiving the care provider's services. Mr. Carroll states that the Department is incorrectly assessing what care recipients would prefer to do. He acknowledges the importance of administrative efficiency and prompt payment but states that the Department could get the information directly from the physician. Mr. Carroll also states that what would happen on appeal may be another matter and that a care recipient might have to make another decision at that juncture. Last, Mr. Carroll states that many care recipients need care, have no other care available, and should not be forced to disclose their health condition to persons who have no need to know their confidential information.

Departmental Response:

A care recipient's medical information is a statutorily required element of a valid claim for PFL benefits. Therefore, a care provider's (claimant) eligibility heavily depends on whether the care recipient has a serious health condition that warrants the participation of the care provider. If these essential requirements are not met, the claimant will be determined ineligible and denied benefits.

To facilitate prompt and accurate claim determination it is incumbent upon the Department to be able to discuss all facts related to the claim including the care recipient's serious health condition with the care provider as it relates to his or her eligibility. Shared liability for a PFL claim significantly increases the need for effective coordination between the voluntary plan, state plan (Department) and the care provider. Without free discussion of all aspects of the claim, such coordination is not possible. The authorization provided for in subdivision (d)(6) gives assurances to the Department that appropriate authorizations to do so have been obtained.

All claimants who are disqualified from eligibility have the right to appeal their case to an administrative law judge of the Unemployment Insurance Appeals Board. The provisions of California Code of Regulations, title 22, section 5062, subdivision (d) guarantee all claimants the right to review their case file at such hearings. The same provisions also give claimants the right to examine and rebut evidence against them. Claimants' right to a fair hearing would therefore be violated if they were deprived of access to their care recipient's medical information in the case files. At the same time, state and federal law prohibit disclosure of an individual's medical information without his or her prior written consent. Therefore, to protect the rights of claimants and care recipients alike, voluntary plans must ensure that all claimants to obtain their care recipients' disclosure authorization.

2. Summary of Comments:

Mr. Carroll suggests inserting a cross-reference in proposed Section 2712-2, subdivision (d)(14), regarding instructions for authorized representatives.
Mr. Carroll states that adding a cross reference here to California Code of Regulations, title 22, section 3303-1(a) would remind readers that "authorized representative" has an established definition.

Departmental Response:

Mr. Carroll most likely intended to refer to Section 3302-1, subdivision (a), which defines authorized representative. The Department has incorporated his suggestion to add a cross-reference in Section 2712-2, subdivision (d)(14) to that definition.

FISCAL IMPACT:

Anticipated costs or savings in federal funding to the State: None

Anticipated costs or savings to any State Agency: None

Anticipated costs or savings to any local agency or school district: None

Significant statewide adverse economic impact: The Department does not anticipate this regulatory action will result in any costs to the federal government, to State government, to local county governments, to private individuals, or to businesses and small businesses. Thus, no costs were shown on the Economic and Fiscal Impact Statement.

The Department has made an initial determination that the proposed regulatory action will not have a significant statewide adverse economic impact directly affecting businesses including the ability of California businesses to compete with businesses in other states because any costs associated with the FTDI program are the result of the enactment of the legislation and not the implementation of the regulations. The Department has determined that the proposed regulatory action will not affect the creation or elimination of jobs within the State of California; the creation of new businesses or the elimination of existing businesses within the State of California; or the expansion of businesses currently doing business within the State of California.

The costs impact on representative persons or businesses: The Department is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed regulatory action.

Anticipated impact on housing costs: The proposed regulatory action will have no effect on housing costs.

Anticipated nondiscretionary costs or savings imposed upon local agencies: None

SMALL BUSINESS IMPACT:

The Department has determined that the proposed regulatory action will have no effect on small businesses because it does not impose any new mandates on small non-voluntary plan businesses. The proposed regulatory action does not require that small businesses take any action or refrain from taking any action in regards to conducting business.

LOCAL MANDATE DETERMINATION:

The Department has determined that the proposed regulatory action will not impose any new mandates on school districts or other local governmental agencies or any mandates which must be reimbursed by the State pursuant to Part 7 (commencing with section 17500), Division 4 of the Government Code.

CONSIDERATION OF ALTERNATIVES:

In accordance with section 11346.9(a)(4) of the Government Code, the Department has determined that no alternative considered would be more effective in carrying out the purpose for which this action was intended than the proposed regulatory action. The Department has also determined that no alternative would be as effective and less burdensome to affected private persons than the proposed regulatory action.

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